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The Galena Park Special Program is an effort on the part of the school administration to detect, at the earliest time, any student problem which may lead to difficulties in school adjustment. All phases of pupil personnel services are placed under one coordinator to expedite services to the child in difficulty.

Early detection of potential problem children is facilitated via a preschool clinic. All children who will be entering the first grade in the fall visit the spring clinic with one or both parents. An effort is made to detect health problems as well as to assess the child's social maturation. All families concerned are contacted by telephone, and an appointment is made at the rate of 15 to 20 children per half hour. Visual screening, audiometric evaluations, dental evaluations, and social-emotional-readiness evaluations and assessments are performed by qualified personnel. At least twelve different stations with as many attendant personnel are required for the most efficient functioning of the clinic. Once the child enters the first grade he may advance by several routes, depending upon the judgments of the evaluators. He may advance regularly, pass through special transitory classes, or be detained a year to permit more adequate adjustment to the school situation.

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EARLY DETECTION AND PROGRAMMING FOR CHILDREN WITH SCHOOL ADJUSTMENT PROBLEMS*

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EARLY DETECTION AND PROGRAMMING FOR CHILDREN WITH SCHOOL ADJUSTMENT PROBLEMS

By: F. E. McGahan

There is general agreement among all disciplines in the field of child growth and development that the earlier the detection of a possible difficulty, the greater the chances for correcting or alleviating the difficulty. There are two outstanding cruxes; namely, designing an adequate detection program that can be staffed with the already existing special service personnel, with a minimum utilization of the more skilled outside consultants; and secondly, the interpretation of the program to the extent that its findings and judgments will be accepted and implemented by the administrators and class teachers and the general public.

It will be the purpose of this presentation to describe a specfic program, that of the Galena Park system, so as to make possible the use of the design in other situations, giving its philosophy, its developmental history and, briefly, the detailed mechanics and techniques of operation and administration.

The Galena Park Special Services Program was begun in 1954. The underlying purpose of the program was to improve instruction through helping students who experience some difficulty in meeting the demands of the learning situation or adjusting to the environmental pressures. By and large, this working concept had its origin in the school philosophy which states that the chief purpose of the school shall be the individual welfare of the pupil.

The special service design simply includes all phases of pupil personnel services under one coordinator. The disciplines included are the school nurse, the visiting teacher, the school counselor, the school psychologist, the various areas of special education such as the class teacher, the speech therapist, the remedial teacher, and

the attendance supervisor all working as a team to expedite services to the child in difficulty.

The critical long range needs lay in detecting a deviation before it became multi-involved. Hence, the visiting teacher and the school nurse were teamed together in the institution of what was then called a first grade clinic. This clinic was conducted during the first three weeks of school. Its structure was a simple one. It might be added at this point that inasmuch as there are many pitfalls in all aspects of the public relations surrounding such an effort that every precaution was taken to explain to the administrators, the school faculties and to the public at large that the chief purpose of the clinic lay in devising some plan wherein the services of the nurse and the visiting teacher could be made more meaningful. No attempt was made to be technical or diagnostic. It was simply a screening medium.

The clinic had two main phases; namely, the obvious health factors: body posture, hearing and visual screening, gross motor coordination and obvious physical defects. The nurse noted the deviation and a monitor, usually a mother, recorded the deviation. The social, emotional and intellectual evaluations were next made by the visiting teacher and the coordinator of special services. As the child was interviewed, he was observed for anxiety, aggressiveness, timidity, or any signs indicating a low tolerance for the learning situation. An assessment of his social maturation was also made by determining to what degree the child could care for himself, button his clothes, tie his shoes, take a bath, assisted or unassisted. Finally, the intellectual assessment was made by using such sub tests of the Stanford-Binet, as ability to count to 13, the three command tasks, the repeating of a number of digits backwards and forward, and the drawing of the human figure.

The children were seen in a line formation, usually one-half of the class at a time, with the class teacher present. Three separate sheets of recording paper were used: one to record the nurse's observation as she weighed and measured the child in the line, a second health sheet to record the visual and hearing screening (later two sheets were used...one for each vision and hearing), one for the visiting teacher and one page for the mental evaluation. Later another sheet was added for the dental screening tests made by a local dentist. From the total data derived from this screening process, a judgment was made as to the child's overall readiness for school. Those reflecting a low tolerance were placed on a list for longitudinal follow-up and study. This type of early detection was followed the first four years.

The administrators and the parents asked the special service staff to consider a pre-school clinic in 1958. Thus the second phase of the Galena Park early detection program came into being. To avoid any possible criticism, when the clinic effort moved out into the community, the State Health Department was asked to help plan and, in fact, sponsor the entire conduction of the clinic. Early spring was decided upon as the logical time for the conduction. Inasmuch as the effort became largely at this point a community enterprise, with the special service staff cooperating, a great deal of planning had to go into its structuring and actual operation for the setting up and managing phases.

In order that another community might use the design herein employed, an attempt is made to describe the various phases of setting up and managing of a pre-school detection clinic, as well as the broadening aspects of the evaluations and the implementation of the findings and recommendations.

The Area Council of Parents and Teachers composed of the various individual school units agreed to sponsor the systemwide pre-school clinic. From this council the local health chairmen of the various units were designated as members of the steering committee, with the Area Council president acting as general chairman and the director of special services and the state health people as consultants. This committee holds its first meeting in January. At this time the places for holding the clinic are designated, the procedures for operation are outlined and needed sub-committees are appointed. In each school center at least two people are placed on a telephone committee. These people may or may not ask others to help. As soon as the annual census blanks, carrying the names of the six year old students who will enter school for the first time in September, are completed the parents are contacted by telephone and the child is registered for the clinic. Children are scheduled at the rate of 20 to every 30 minute interval. For example, if the clinic is the first Monday in the following month, 20 children are scheduled for the first 30 minutes, followed by 15 to 20 thereafter, scheduled on 20 to 30 minute intervals, depending upon number to be seen that day. Each child is to be accompanied by one or both parents. As much data as possible is secured on the child in the initial telephone contact. The data to be secured, however, is carefully decided upon by the steering committee.

The best place in which to conduct such a clinic, in the experience of the Galena Park Schools, is a large church. A church situation will provide the necessary needed stations, inasmuch as a minimum of 12 stations is needed; two reception rooms, one for the parents and one for the children, one for the visual screening, three for audiometric evaluations, one for the dental evaluations, and at least five for the social-emotional-readiness evaluations and assessments.

The child comes at this scheduled time, accompanied by one or both parents. He is met by two receptionists, one taking the child to the reception room for children and the other taking the mother to the reception room for parents. The parents are asked to fill out any additional materials that pertain to the clinic assessment. The child is oriented to his first clinic station, that of the visual screening, by the receptionist using a large E playing with the children in getting them ready for the Snellen chart task. On the completion of the forms, the mother together with the child, begins the clinic experience.

First, each child is evaluated for visual functioning using the Snellen chart. Next, the mother and the child go to the dental station. There the dentist talks with the mother and child about oral hygiene and the need for adequate dental care. From here the parents and child are routed to the audiometric station. At this point the hearing and speech functioning of the child are evaluated. Any suspected difficulty is explained to the parent. Usually at least three audiometers are necessary, two for sweep screening and one for rechecks on those suspected of hearing deficits. If there is a definite loss suspected, the mother is so advised and a referral for a complete hearing evaluation is recommended. This concludes the essential physical evaluation.

The psychological evaluation is more involved and hence will be described in more detail.

A minimum of five evaluators are oriented prior to the clinic day as to scope and techniques utilized in the screening assessment. The visiting teacher, the school psychologist, the school counselors, and the director of special services have sufficient competencies to make the evaluations and arrive at a judgmental decision as to the tolerance of the child for the learning situation demands. The tasks used

are those that have been found to be valid in making judgments in the first grade clinic and have finally been incorporated as adequate screening tasks for judging school readiness.

There is a waiting room where both parents and child await their turn. A receptionist directs the next child with his parent to the evaluator. Rapport with the child is secured by asking him if he wishes to color or any other natural contact technique. The parent is seated at a distance but in full view of the task situation. As in the first grade clinic, a minimum of five major performance tasks is utilized. First, the child may be asked such questions as what is his street number, his telephone number, or where he lives in reference to the school, and his birth date. Next, he may be asked to count to 13, to withdraw groups of pennies, 4, 3, 7, 6, etc. He is asked to tie his shoe, or if whether or not, unassisted, he can prepare himself for bed. He is asked to copy the seven geometric figures; to complete the human figure drawing. The child is asked to pick up an object with his right hand or left hand, to make a side step, to make a circle with his thumb and forefinger and stretch to the point where he can see the examiner's nose through the circle. If there is doubt about the child's directionality, the triple command task is utilized. The child is closely observed and his responses interpreted to the parent in terms of his overall readiness for school.

In addition to this test battery, Psychologists from Baylor University College of Medicine and the Houston State Psychiatric Institute take research samples of children and administer test tasks that are calculated to reflect anxiety proneness and tension tendencies, using autonomic nervous system measures. This group is also conducting research in the prediction of adjustment in school, with grant support from the Hogg Foundation.

It will be observed that the above screening test battery is designed to evaluate the whole child: physically, emotionally, socially and intellectually. It will be further observed that a definite attempt is made to determine deficiencies in eye-hand coordination, visual motor perceptual skills and gross motor coordination.

Depending upon the number of children to be screened, the number of lay people who take part in the clinic can be very large.

In the Galena Park System the number of children to be screened usually is close to 1000. This number will make it necessary to change clinic settings a minimum of three times. Approximately 150 children can be seen per day if at least 20 are scheduled on every half hour. It is possible to schedule 20 children every 20 minutes if the readiness examiners can be increased to seven or more.

To be able to follow these pupils longitudinally a judgment is reached on the part of the evaluators as to whether or not a child will need some or a great deal of assistance, or that he can move independently with only good guidance practices to support him. For this purpose children are coded in three groups: 1, 2, and 3. Children who seem to be able to meet all task situations with good thrust and performance skills are numbered in the 1 category. Children whose tensions or deficits are minimal but some caution should be used in placement and programming are carried in the number 2 category. Children who reflect serious deficits in many or all of the skill areas or in the overall physical functioning are categorized in the number 3 group and followed very closely with the appropriate special service support.

Beginning with the 1958-59 school term, those which are designated as transition regular classes were set up in the first three grade levels. These classes are kept at a maximum membership of 18. The teacher is more carefully selected and the in-service training

effort more directed toward depth instructional methodology and child understanding. For example, a child placed in a 1st grade transitional class may move out of this class one of four ways. But, in any case, the decision as to which way a child moves is made by a placement committee composed of the visiting teacher, the school nurse, the class teacher and the local principal, acting on the recommendations of the school psychologist after referral has been made for further psychological evaluation. If in their judgment a greater depth of teaching need is indicated, he, with the permission of the parent, is eligible for special class placement. On the other hand, if a child progresses satisfactorily and indicates strengths that will enable him to compete with the regular pupils, the committee can recommend that he be placed in a regular class. If at the end of the year the child is still not ready for either the small 2nd grade transitional class but doesn't need to repeat the small transition, he can, through the same committee, be recommended for regular 1st grade with the idea of reentering the small 2nd transition at the end of his second school year's experience. Children are not retained more than one year during the first three grade levels. If adequate or satisfactory progress is not possible, special class placement is considered rather than retention.

Results to date have been very good. Above 50% of the students have moved into regular class placement during the first year. Approximately 30% of the remainder have moved out during the second year. The remaining 20% have either been placed in special classes or have moved vertically to the next grade level.

In summarizing, the plan for early detection and programming for pupil adjustment difficulty in the Galena Park Schools has developed out of a felt need on the part of the school people and the community to prevent difficulty rather than attempt to correct hard core

adjustment problems. The plan stemmed, by and large, from a sincere desire on the part of the school administrators to implement its philosophy. The design for such service was made possible through the special service organizational structure.

The pre-school clinic arose from a felt need on the part of the school and community to broaden the basis of an early detection design to include a greater special service and community participation effort. This design places the primary responsibility for clinic planning and operation under the responsibility of lay leadership and the utilization of outside community consultantship.

Finally, this type of clinic design makes possible one of the finest public relationship laboratories. People gain insight into how the school is managed, the basic needs of the child and how to go about getting help if their child gets into difficulty either in or outside the school situation. It also provides opportunity to counsel with parents at a time when their interest is a positive one rather than a defensive one. In other words, they are not having to defend any of their basic beliefs in child handling and developmental problems. It is the first official contact the family has had with the school as an institution.

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